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NHS10YP

An Analysis of the Implications for General Practice

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Background:

The NHS 10 Year Plan (hereafter referred to as "10YP" or simply the "Plan"), published on 3rd July 2025, is the Labour Government's flagship policy document on the reform of the NHS. It is based on the Darzi review of the NHS commissioned in 2024 which described the NHS as being in a "critical condition"[1] and called for greater shift of healthcare into the community, and, particularly, recommended the concept of a "neighbourhood NHS," with the expansion, adaptation, and combination of GP and other community services.[2]

The 10YP is 168 pages long with a bibliography of 227 citations. It would be neither helpful nor practical[3] to dissect it line by line. Therefore, this analysis focuses on the key components of the plan which affect GP practices and their contracts, and particularly the threats to General Practice as a profession.

Introduction:

The 10YP opens its Executive Summary with four key problems with the NHS highlighted by the Darzi Report, the first of which is "many cannot get a GP or dental appointment."[4] This unfortunately somewhat undermines every premise of the 10YP as it is predicated, as ever, on the election-centric priority of access, regardless of data. GPs are providing consistently more access than ever before, despite the number of GPs per head of population dropping over time.[5] The NHS ranks consistently high in the world for access, yet one of the worst for outcomes[6] with GP access ranking second only to the Netherlands.[7] Despite this, the 10YP opens its argument based on the unevidenced axiom that access is not only poor, but is the causative factor in the NHS' poor outcomes.

Clearly, widespread NHS reform is urgently needed. Indeed, it is the consistent view of the GP profession that the current chronically underfunded GMS contract is no longer fit for purpose and a new contract is needed that incentivises the continuity of care and family doctor model that patients want and need.[8] However, despite this pressing need and despite the Government's purported emphasis on the place of General Practice in its 10 Year Plan, the term "GMS" does not appear anywhere either in the 10YP, or the Darzi Report. Despite the letter to the profession from the Secretary of State on 18th March promising a "new substantive GP contract,"[9] there is no mention of any such contract on a practice level anywhere in the 10YP.

It is reasonable to therefore conclude that the Government have no intention of contractual reform and improvement at a practice level, but rather seek to replace the current GP model with something else, laid out in the 10YP. It is this threat which this paper will further analyse.

[1] Darzi Report, p11, https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england
[2] Ibid., p12
[3] Brandolini's Law
[4] NHS 10 Year Plan, p8, https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future
[5] Royal College of GPs, 26th June 2025, https://www.rcgp.org.uk/representing-you/key-statistics-insights
[6] Commonwealth Fund, 'Mirror Mirror 2024,' https://www.commonwealthfund.org/publications/fund-reports/2024/sep/mirror-mirror-2024
[7] Pulse, August 2024, https://www.pulsetoday.co.uk/news/contract/uk-worst-on-hospital-waits-but-best-on-gp-access-10-country-survey-shows/
[8] Conference of England LMCs 2021 & 2023
[9] Letter from Secretary of State to GPCE Chair, 18th March 2025, https://www.bma.org.uk/media/ypvj4m0m/sofs-letter-to-bma-gpce-20250318.pdf

THE "NEIGHBOURHOOD HEALTH SERVICE"

The 10YP makes repeated reference to what it refers to as the "Neighbourhood Health Service" which is based on the principle that "care should happen as locally as it can."[10] This has already begun to be rolled out at significant speed by the Government, with forty-two first phase pilots of the rollout set to be in place by September.[11] Applications are already being received for these areas, with a closing date as soon as 8th August.[12] The features the "Neighbourhood Health Service" is described as follows:

"A Neighbourhood Health Centre in every community"	• These seem very much to be a reinvention of "Darzi Centres" or "Polyclinics" which were first proposed by Lord Darzi in 2007 under the last Labour Government, but were widely criticised and ultimately scrapped in 2010.[13] • It is worth noting that the opening times for these centres are set to be ***"12 hours a day and 6 days a week"*** – There is a real risk and likelihood that the GMS definition of core hours will therefore be amended. • NHCs are promised ***"to end hospital outpatients*** *as we know it by 2035."* This seems, to put it lightly, rather optimistic. • The Plan gives little clarity as to how these "centres" will coexist with extant GP estates. Indeed, the billions in estates funding needed for these centres can only be realised if a commensurate number of GP surgeries close, as was found the last time this was tried.[14] Indeed, Wes Streeting has said in the past he wants to "replace GP surgeries with modern health centres."[15] • Notwithstanding the point above, the 10YP suggests that these centres will be funded by *"Public Private Partnership (PPP)"*[16] as soon as the autumn budget in 2025. This is a remarkably similar (arguably the same) model as Private Finance Initiatives (PFI) under the Blair Government.[17] To be fair, the Plan does admit PFI didn't work well, and suggests lessons have been learned, but gives no clarity as to what or how. • The Plan further elaborates on the PPP proposal by suggesting *"private financing of revenue-raising assets"* and alarmingly includes *"the potential to access* ***low risk pension capital*** *for the development of such assets."* • Notably back in 2008 when similar centres were last tried, a comprehensive report by the Kings Fund concluded: *"A major centralisation of primary care is* ***unlikely to be beneficial for patients,*** *particularly in rural areas,"* and ***"substantial cost savings are unlikely to be made."***[18] It is interesting that although the Kings Fund is cited multiple times in the 10YP, this extensive paper is not.
"Introduce 2 new contracts, with roll-out beginning next year, to encourage and allow GPs to work over larger geographies and lead new neighbourhood providers."[19]	• The Plan proposes "2 new contracts" for the "Neighbourhood Health Service" • The first contract is to be held by **"Single Neighbourhood Providers" (SNPs)** which will hold a patient list of ~50k patients. The Plan suggests current PCNs will be ideally placed to hold these contracts. These SNP contracts are described in the Plan as delivering ***"enhanced services*** *for groups with similar needs over a single neighbourhood,"* which raises the question of whether DES/LES contracs will be removed from individual practice level. Indeed, at NHSE webinars and meetings, senior NHSE leadership have suggested that these SNPs will be able to hold a merged GMS and PCN DES contract in their own right. • The second contract is to be held by **"Multi-Neighbourhood Providers" (MNPs)** which will cover a patient population of ~250k. These MNPs, "will deliver care that requires working across several different neighbourhoods." Notably, these MNPs are described as *"working across* ***all GP practices****... in their footprint."* This raises the significant risk of loss of autonomous identity of individual GP practices, as they become horizontally integrated into an MNP, and essentially serve as a *de facto* branch surgery of a monolithic superpractice. • The Plan states further that: *"We will also give integrated care boards (ICBs) freedom to contract with* ***other providers*** *for neighbourhood health services,* ***including NHS Trusts."*** Essentially this can be interpreted as any provider of suitable scale can hold these MNP contracts. These contracts would be awarded by the ICB, without the necessary consent or autonomy of incumbent practices.

[10] 10YP, p9
[11] Pulse, '42 deprived areas to be prioritised for 'neighbourhood health' from September,' 9th Jul 2025, https://www.pulsetoday.co.uk/news/nhs-structures/42-deprived-areas-to-be-prioritised-for-neighbourhood-health-from-september/
[12] NHS England, https://www.england.nhs.uk/long-read/your-invitation-to-be-involved-in-the-national-neighbourhood-health-implementation-programme/
[13] GP Online, May 2010, https://www.gponline.com/lansley-halts-darzi-polysystem-plans-london/article/1004444
[14] Guardian, Jun 2008, https://www.theguardian.com/society/2008/jun/11/nhs.health1
[15] Guardian, Jan 2023, https://www.theguardian.com/society/2023/jan/07/labour-would-tear-up-contract-with-gps-and-make-them-salaried-nhs-staff
[16] 10YP, p16 & p139
[17] Gov PFI/PPP guidance, 2018, https://www.gov.uk/government/publications/pfippp-finance-guidance
[18] Kings Fund, 'Under One Roof,' Jun 2008, https://assets.kingsfund.org.uk/f/256914/x/9aa1bc1f01/under_one_roof_2008.pdf
[19] 10YP, p32

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*"Make sure persistent poor-quality care results in the decommissioning or contract termination of services **or providers**, no matter the setting, no matter whether the provider is in the NHS or independent sector, and no matter whether they are a GP practice or an individual NHS trust."*[20]	• Whilst it is difficult to argue against quality control and contract action against poor quality, the concurrent divesting of practice autonomy risks fostering a hostile environment where practices are penalised for failings outside their own control. • The Plan also states: *"We will task, within the next 12 months, ICBs and NHS Regions with assessing where such action is needed across all services."* – This has already started, with the LMC aware of regions being given a list of the 100 "worst" practices with objectives for contract action. The LMC has no confidence in the evidence base for this list, as it contradicts our own extensive practice level metrics.
*"**Where the traditional GP partnership model is working well it should continue,** but we will also create an alternative for GPs. We will encourage GPs to work over larger geographies by leading new neighbourhood providers."*	• The traditional GP Partnership model is only mentioned this one time in the entire 10 Year Plan, and the term "GMS" does not appear anywhere in the Plan, or in the Darzi Review. It should be fairly obvious that the GMS partnership model has no place in the Government's vision for the NHS, and will only survive where it is unavoidably necessary, such as in very rural areas, or where it is fitting the scale of the 10YP, ie: in very large super-partnerships. • The objective of this Government to abolish GP partnerships should not come as a surprise as the Secretary of State said he would do this in 2023.[21] Wes Streeting described GPs as operating a *"murky opaque business"* and told the Times, ***"I'm minded to phase out the whole system of GP partners** altogether and look at salaried GPs working in modern practices alongside a range of other professionals."* The same year, the now Prime Minister said on BBC Radio 4, ***"The partnership model in many cases is coming to an end of its life** and we need to have more salaried GPs."* He also said, *"The NHS must become a Neighbourhood Health Service."*[22] • The profession has no written assurance of the preservation of the partnership model, or of a new GMS contract which will safeguard its survival. On 18th March 2025, the day before the Special England Conference of LMCs, the Secretary of State wrote a letter to the Chair of GPCE pledging *"a new substantive GP contract within this parliament."* However, in the same letter, the SoS promises, *"to establish a modern general practice **at the heart of a neighbourhood health service."*** Further, neither the terms "partnership" nor "GMS" appear anywhere in the letter. Given the context of the 10YP, and the absence of any mention of GMS or a future for partnerships, ***one can only conclude that the Neighbourhood Health Service model, with 50k SNPs and 250k MNPs, IS the "new GP contract."***

"ANALOGUE TO DIGITAL"

The Plan lays out extensive digital and tech aspirations which it argues will save money and capacity, and will "take the NHS from the 20th century technological laggard it is today, to the 21st century leader it has the potential to be."[23] These proposals include:

*"To make the move 'from bricks to clicks' we will for the first time ever in the NHS, give patients real control over **a single, secure and authoritative account of their data and single patient record** to enable more co-ordinated, personalised and predictive care."*	• The call for a Single Patient Record (SPR), as GPs are the Data Controller for the GP record, represents possibly the greatest legal risk to partners in recent history. Practices would retain all the substantial GDPR risk with ever diminishing control. The UK LMC Conference voted against giving up this status as record holder, as GP data controllership is a hallmark of the independent contractor model;[24] *loss or sharing of data controllership would facilitate the abolition of that independent contractor model.* • The Plan proposes linking pharmacies into the single patient record, which would necessarily include write access as well as read, and also the merging of the medical record with the care record, allowing read/write access to: *"the voluntary sector, from social enterprises, social care, community groups, or local government"* (p50), threatening the integrity and confidentiality of the medical record. • According to the Plan's patient consultation, the public *"readily accept the use of their data for applications beyond direct care, **as long as strict privacy and security conditions are in place and met."*** The two halves of this statement are by no means mutually compatible, as such a vague, catch-all approach to informed consent places patients and doctors at risk, especially considering the comments below • The following statement gives a concerning suggestion of an intention to sell patient data for profit: *"By unlocking the untapped potential of NHS datasets, we will help the health service make **a far greater contribution to our national prosperity.**"* The Plan's further intention that, *"deidentified data will be made available to scientists, research **and entrepreneurs**"* raises further concerns about data protection and informed consent. Despite the Plan's assertion that *"commercialisation is not the same as sale,"* this is somewhat euphemistic; as patient data is clearly supposed to be being sold.

[20] 10YP, p14
[21] Guardian, Jan 2023, https://www.theguardian.com/society/2023/jan/07/labour-would-tear-up-contract-with-gps-and-make-them-salaried-nhs-staff
[22] Pulse, May 2023, https://www.pulsetoday.co.uk/news/breaking-news/gp-partnership-model-at-end-of-its-life-says-labour-leader/
[23] 10 YP, p10
[24] UK Conference of LMCs 2025

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*"We will make this possible through new legislation that places a duty on every health and care provider to **make the information they record about a patient, available to that patient.**"*[25]	• Legislation is already in place to grant the data subject access to information held about them.[26] This seems to be suggesting data access regardless of request by the subject and without regard for risk to the subject or others. Indeed, the same page of the Plan says: *"We will also legislate to give patients access to their SPR **by default.**"* • The BMA has warned of the extensive risks of unfettered total access to records as a default: for example such as patients seeing potentially life-changing test results before a formal report has been completed and without the opportunity for explanation by a doctor; or in situations such as domestic abuse and coercive control.[27] • In order to comply with data protection legislation, and to prevent harm to patients and associated third parties, vast amounts of workload would be necessitated in order to carry out safe redaction and prevention of data breaches. Given the complexity and potential for harm arising from breaches pertaining to the medical record, providing real-time access to cotemporaneous medical records is frankly impossible under GDPR without placing the Data Controller, and patient, at significant risk. • Currently, as the Data Controller for the GP-held patient record, GPs are medicolegally exposed for the consequences of data breach, regardless of whether this is forcibly imposed upon them by way of contract clause. If this aspect of the 10YP is to be implemented, then the Government will have to underwrite all medicolegal penalty risk mandated by GDPR, by way of CNSGP.The Plan itself acknowledges the "rising legal costs of clinical negligence claims."[28]
*"Primarily, we will harness automation to free up clinical time. Through this Plan, **we will make AI every nurse's and doctor's trusted assistant** - saving them time and supporting them in decision making."*	• The Plan claims that AI scribes will: *"end the need for tasks like **clinical note taking,** letter drafting and manual data entry."*[29] This is extremely naïve and idealistic. Not only is the art of clinical note taking in General Practice extremely nuanced, any risk from omission of key information or inclusion of harmful information would medicolegally fall to the GP. • The Plan also claims that AI will *"help clinicians choose the most effective, personalised treatments,"* however no evidence base is provided to support this claim, aside from a single anecdotal example of use for a specific clinical indication. • It is also important to note that whilst the Plan acknowledges the current woeful state of the GP IT estate (p46) it offers no solution whatsoever to bring the IT infrastructure in primary care up to the required standard. When one considers that GPs are often delayed in starting their morning clinic due to the wait for the computer to boot up, and considering the demonstrable national vulnerability in such systems,[30] the proposal to roll out state of the art, yet undesigned AI systems, with no plan to update the accompanying IT estate seems something of an oversight.
*"The **My NHS GP tool will provide a single, trusted source of instant advice for patients** who need non-urgent care, available 24/7. **It will use AI-algorithms** to take a patient's descriptions of their worries or symptoms, ask the right follow-up questions and provide personalised guidance."*	• The Plan offers no clarity on the evidence behind this pledge or how it will avoid the significant pitfalls and financial losses of attempts by previous Governments.[31] • Whilst the Plan goes on to argue that, *"My NHS GP **will [future tense]** use evidence-based techniques,"* this hypothetical evidence-base is not cited, and presumably will be sought out later on, evidently after the decision to implement such a process in the first place. • General Practitioners' primary skill lies in our appropriate management of risk; the ability to make a risk assessment of a patient in a matter of minutes takes years of training and thousands of hours of clinical experience to master. The idea that an app can accurately and safely risk stratify undifferentiated illness without over-estimating risk and substantially increasing A&E and ambulance service workload seems staggeringly naïve and an insult to the profession of General Practice.
*"Through the app, **patients will be able to choose their preferred provider,** whether it delivers the best outcomes, has the best feedback or is simply closer to home, through My Choices."*	• No clarity is offered as to what happens to continuity of care, follow up, or shared care if a patient chooses secondary care treatment in Cumbria but their "neighbourhood" is in Cornwall. Furthermore, zero explanation is given as to how funding would practically follow the patient • The Plan suggests the dilution or even total removal of the role of the GP as "gatekeeper" to the rest of the system; whilst being a welcome abrogation of referral workload for General Practice, this will have a catastrophic effect on waiting times. • Indeed, the Plan proposes: *"The My Specialist tool will be where **patients can make self-referrals to specialist care** where clinically appropriate."* This seems an illogical step considering current NHS referral backlogs.

[25] 10YP, p48
[26] GDPR Article 15
[27] BMA, Accelerated Access to GP-Held Patient Records, https://www.bma.org.uk/advice-and-support/gp-practices/gp-service-provision/accelerated-access-to-gp-held-patient-records-2023
[28] 10YP, p132
[29] Ibid., p29
[30] Crowdstrike Outage, Pulse, July 2024, https://www.pulsetoday.co.uk/news/breaking-news/emis-affected-amid-global-it-outage/
[31] "Babylon Health: the failed AI wonder app that 'dazzled' politicians," https://theweek.com/health/babylon-health-the-failed-ai-wonder-app-that-dazzled-politicians

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"A DEVOLVED AND DIVERSE NHS: A NEW OPERATING MODEL"

The structure and governance of the NHS is also being subject to top-down reorganisation. The ICB Model Blueprint[32] alluded to most of these changes, and constituents are urged to read the BMA response to that Blueprint, which was sent to members.[33] The bottom line of these changes is devolution of many commissioner functions down to providers at scale and greater integration of those providers. The changes proposed are:

*"To realise the ambition of this Plan, **we will create a new NHS operating model,** to deliver a more diverse and devolved health service. Today, power is concentrated in Whitehall, rather than distributed **among local providers,** staff and citizens."*	• The Plan proposes ICBs become *"strategic commissioners of local healthcare services,"* while providers will be delegated with more freedom and control dependent on performance, in what the plan refers to as "earned autonomy." The Plan gives no clarity on what metrics this performance will be measured against, however the Plan promises a "failure regime" to act against providers who fall short of these undefined metrics, with measures such as forcibly changing their leadership or placing them provider into administration *"so it can be taken over by another."*[34] • The Govt place a large emphasis on Foundation Trusts in the Plan, aiming to *"reinvigorate and reinvent the NHS foundation trust (FT) model for a modern, integrated health system."* To that end, the Plan promises a *"new wave of FTs in 2026,"* and, most concerningly, states: *"our ambition is that, by 2035, **every NHS provider should be an FT.**"* The plan makes no differentiation between "providers" and one must logically conclude that this objective applies to the 250k population MNPs mentioned earlier. • Therefore, given the aforementioned objective for the SNP/MNP neighbourhood provider model to replace the GMS partnership model, one can conclude that *the fear by GP practices that they will be taken over by Trusts is actually better described by the reality **that they will be integrated into structures that will inevitably become Trusts.*** • Some may argue that the above end point is immaterial if the organisation set to become an NHS FT is a GP-led SNP/MNP body in its own right, given the aforementioned emphasis in the plan on "earned autonomy." However, any such autonomy is illusory given that: a) Such autonomy is entirely variable in its extent and existence, which is dependent on the discretion of the DHSC b) By being an FT, the provider is fully vertically integrated into the NHS and any prior corporate or constitutional independence would be lost. c) GPs will only have a leadership role insofar as they are directed to performance manage and monitor their own colleagues
*"For the very best NHS FTs - that have shown an ability to meet core standards, improve population health, form partnerships with others and remain financially sustainable over time - we will create a new opportunity **to hold the whole health budget for a local population as an Integrated Health Organisation (IHO)."***	• This proposal in the Plan to allow large, at scale providers to make contracting and budgetary decisions normally reserved to commissioners and ICBs seems a rather substantial conflict of interest, and somewhat goes against the theory of maintaining a split between purchaser and provider. • The Plan aims to, *"designate a small number of these IHOs in 2026, with a view to them becoming operational in 2027. **Over time they will become the norm.**"* – This seems a dangerously accelerated timeline to delegate budgets on such a scale without a supporting evidence-base. • In terms of how this affects GPs, there seem to be three possibilities: a) An FT becomes an IHO, and is responsible for all budgets for its population area, including GP and the rest of Primary Care. Such an IHO seems rather unlikely to preferentially defund itself, which calls into question how this fits with the "left shift" of funding moving from secondary care to the community. b) A GP-led collaborative/Federation becomes an IHO, but all independence is lost, as the IHO is vertically integrated into the wider NHS system, as the Plan says: "*They [IHOs] will always and only ever be **NHS organisations**"* (p81). c) Large corporate providers who are successful as MNPs and granted IHO status become responsible for large portions of the NHS budget. In concert with a revival of pseudo PFI and private investment in the medical record, this looks like NHS privatisation. Indeed, the Plan's aspiration that IHOs, *"will be allowed to keep the savings to reinvest in better patient care, new capital projects, digital transformations, new partnerships **or even commercial support for start-ups** and SMEs with significant promise,"* corroborates this concern. • The Plan also promises that the new operating model will, *"through IHOs, **align investment and savings to occur in the same place** for the first time - meaning collaboration and innovation are never blocked because the cost and the benefit accrue in different organisations or settings."* – This suggests the significant and regular savings made in General Practice will be available to plug the significant and regular losses made in the acute sector, again undermining the left shift.

[32] Model ICB Blueprint https://www.digitalhealth.net/wp-content/uploads/2025/05/Model-Integrated-Care-Board-%E2%80%93-Blueprint-v1.0.pdf
[33] Pulse, 'New ICB model poses 'existential threat' to independent GP practices, BMA warns,' Jul 2025, https://www.pulsetoday.co.uk/news/nhs-structures/new-icb-model-poses-existential-threat-to-independent-gp-practices-bma-warns/
[34] 10YP, p80

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"AN NHS WORKFORCE FIT FOR THE FUTURE"

The Plan cites the recent 2023 NHS Long Term Workforce Plan,[35] but only insofar as to apparently reject it, describing it as "a fiction."[36] Interestingly, scant evidence is provided to support the argument that the 151 page Workforce Plan with 270 citations is a fiction. Instead, the 10YP promises to write a completely new workforce plan "later this year." The key workforce features of the 10YP are:

*"Overall, while **there will be fewer staff in the NHS in 2035 than projected by the 2023 workforce plan,** those staff will be better treated, have better training, more exciting roles and real hope for the future - and so they will each achieve much more.*	• The Plan wastes no time in promising to "harness the potential of automation" in order to meet this aim of fewer staff. • The Plain aims to free up "£13 billion" in workforce costs by streamlining through automation and AI. • The idea of planning to reduce workforce based on the assumption of that work being done by as yet undeveloped, theoretical apps, particularly in the context of a current NHS workforce crisis, seems somewhat high risk.
*"The NHS appraisal system, and professional regulators' revalidation systems, need to transition to a world of **real-time feedback and continuous skill development.** We have asked professional regulators to renew their revalidation systems to that end."*	• This seems to suggest a move back toward the previous model of appraisal, rather than the post-2020 "light touch" model. Words like "real-time" and "continuous" raise concerns about increased bureaucracy, red tape, and non-clinical time burden for GPs, and increased regulatory burden on GPs in general. • The Plan describes this, somewhat euphemistically, as, *"a healthy combination of robust accountability and continuous self-improvement"*[37]
*"…promote acquisition and retention of **generalist skills** required for the Neighbourhood Health Service."*	• The Plan makes some statements on workforce which have extremely alarming implications for the future of GPs as a profession • The term "GP" only appears once in the entire workforce chapter of the 10YP, in the context of research. Rather, the Plan extensively describes other roles and specialties which will be working in the "Neighbourhood Health Service." • The Plan suggests SAS doctors will be deployed to work in primary care settings, describing such doctors as: *"senior decision makers who have important **generalist** skills and can work **autonomously** in clinics in community settings."*[38] The BMA has made it clear, by previous LMC Conference policy, that it opposes such an idea.[39] • The Plan promises to increase "Nurse Consultants" and "Consultant Midwives" and other AHPs in the Neighbourhood Health Service, but makes no mention of the role of the GP in this setting. Whilst the Plan does promise to recruit "thousands more" GPs, it makes no mention of their role in this new system.

"PRODUCTIVITY AND A NEW FINANCIAL FOUNDATION"

The Plan is vague on detail of how these reforms will be financed, and how funding will flow, particularly to General Practice, in the future. Whilst the Plan is clear that "£29 billion in investment will fund the reforms"[40] there is no clarity whatsoever on how this is allocated. Furthermore, in the context of ICBs being forced to cut their spending by 50%,[41] it is hard to see how any of these reforms will be practically deliverable. Nevertheless, some key financial details are discussed below:

*"**In the next 3 years** we will make a start on the journey to establishing a new financial foundation."*	• The Plan repeatedly makes it clear that there is no new money expected into Primary Care (and therefore General Practice) until 2028 at the earliest.[42] The Kings Fund clarifies this further by explaining that the £29 billion promised by the Chancellor, *"is the difference in real terms between NHS England's day-to-day budget in 2023/24 and planned spending in 2028/29."*[43] Ergo, no new investment is coming to General Practice, aside from incremental annual GMS renegotiations, until at least 2028. • Rather, the Plan says the following regarding how it will fund the early phases of the 10YP Reforms: *"Our plan to **remove deficit support funding** (worth £2.2 billion in 2025 to 2026) starting from financial year 2026 to 2027 will free up funding to allow us to move resources more quickly to areas of higher health need."*[44] This begs the obvious question of what happens to that ~£2.2 billion worth of debt.

[35] NHS Long Term Workforce Plan, 2023, https://www.england.nhs.uk/wp-content/uploads/2023/06/nhs-long-term-workforce-plan-v1.21.pdf
[36] 10YP, p97
[37] Ibid., p100
[38] Ibid., p103
[39] UK Conference of LMCs 2023
[40] 10YP, p7
[41] NHS Confed, March 2025, https://www.nhsconfed.org/news/nhs-confederation-responds-reports-icb-and-provider-cost-cutting-orders
[42] 10YP, p136
[43] Kings Fund, June 2025, https://www.kingsfund.org.uk/insight-and-analysis/blogs/comprehensive-spending-review-2025-mean-nhs-health-care
[44] 10YP, p137

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*"To support the shift of care away from hospital settings towards neighbourhood care, we will develop year of care payments (YCPs), through test and learn approaches. These allocate a **capitated budget for a patient's care over a year**, instead of paying a fee for a service. "*	• These "YCPs" are the Plan's answer to reform the Carr-Hill formula in General Practice, as well as replace the bloc contracts provided to Trusts. • Importantly, these YCPs, *"include all primary care, community health services, mental health, specialist outpatient care, emergency department attendances and admissions. **These will be consolidated into a single payment.**"* This strongly suggests that budgets between Primary and Secondary care will be indistinguishably merged, and also any previous funding specific to GP will be more broadly simply labelled "primary care." *This payment structure is incompatible with the current GMS core funding process and **therefore can only mean the end of GMS.*** • The Plan goes onto say that these YCPs will begin being piloted in the next financial year, starting with the pilot systems signing up this summer: *"We will begin intensive work with a small number of 'pioneer' systems who are already further advanced in designing their new care model **to implement notional YCPs."*** • Further clarification is then given on dismantling the current bloc contracts for urgent and emergency care, to *"encourage a shift in UEC activity into the community."* – Given the aforementioned changes to provider contracts through SNPs & MSNP, there is a real risk here that GPs will find themselves fully integrated into the same providers as Out-of-Hours (OOH). *Many GPs have expressed concerns about OOH being forced back into their contract, in a reversal of 2004, **however the actual risk is more likely the other way around, with GP practices being merged into OOH providers.***

SUMMARY POINTS:

1. The 10YP poses the greatest existential threat to the GP Partnership Model in living memory. If the plan is implemented as written, **it seems inevitable that GP Partnerships will be largely extinct within 10 years,** aside from in very rural areas where there is no alternative, and very large super-partnerships which already fit the 10YP Neighbourhood Model. The only way a Partnership could conceivably exist outside this Plan, would be outside the NHS, offering a solely private service similar to ~20% of dentists.[45]

2. **The promise by the Secretary of State made in his letter of 18th March 2025 for a "new substantive GP contract" must be reasonably concluded to mean THIS contract described in the 10YP:** of SNPs/MNPs rather than practices; funded by YCPs rather than GMS; integrated into IHOs under direct oversight of DHSC. Contrary to the hopes of the profession, there is no conceivable prospect of a new core practice-based GP contract to replace GMS which allows practices to operate autonomously as they have done for the past 77 years of the NHS.

3. The medium-term future is likely to include enhanced services being bundled and offered at SNP/MNP level rather than practice level. **Practices will then find themselves funded only on Global Sum/Core with little choice but to integrate into those structures given current practice unlimited liability.**

4. **The Plan has a clear objective to make the entire GP workforce salaried.** If the plan is implemented, GPs can expect to become salaried either under Trusts, or under over providers; although such other providers will inevitably become *de facto* Trusts under the proposed FT/IHO reforms. Regardless of the overarching organisation, GPs will be on similar terms of engagement to secondary care colleagues.

5. The unification of all community services under one umbrella of "Primary Care" and the "Neighbourhood Health Service" **threatens the very existence of the GP as a unique profession.** The overlap of the role of the GP with other allied health professionals, and even with Specialist/SAS doctors, undermines the unique training and experience of the GP and its unique identity as Expert Generalist; unchecked, this risks the loss of the profession itself, and its dilution into the wider medical workforce.

6. The merging of all community services under MNPs and IHOs will inevitably lead to the re-unification of in-hours services with out-of-hours (OOH). **GPs can expect to be given job plans which would involve them working any manner of shift pattern regardless of the time of day/week/year,** as these will be at the determination of their overarching employing body.

[45] Dentistry UK, June 2024, https://dentistry.co.uk/2024/06/10/introducing-private-dentistry-into-your-practice/

NEXT STEPS:

The LMC will be publishing guidance for practices and allied providers in the coming weeks and months. In the meantime, your GPC Reps are representing your concerns at national level within the GPC/BMA structure. **We are calling on the GPC to re-enter formal contractual dispute with the Government based on the impending threat to our profession evidenced by the 10 Year Plan**, and to make preparations over the coming months for consultation and communication with the profession with a view to escalation of all forms of action, as per resolutions of the 2025 Special England Conference of LMCs. If you have not already done so, please contact your GPC Representative via the BBOLMCs Collective Action WhatsApp group to express your views. If you require access to this group, please contact the Secretariat.

BBOLMCs will also be putting out a detailed survey to constituent GPs to seek your views on what action you may be willing to take to mitigate or avoid the above threats.

If any constituent needs support, or advice, on any of the contents of this analysis, or on the future of their career and/or practice, as always we urge you to contact us in strict confidence at assistance@bbolmc.co.uk

--- ENDS ---

Dr Matt Mayer
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Chief Executive

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Chair of Board

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